

Domiciliary Outreach Evaluation Form

Veteran's Name: _____

DATE: _____

SSN: _____

DOB (M/D/YYYY) _____

☐ Married ☐ Separated ☐ Divorced ☐ Coupled ☐ Single

Reason(s) for wanting Domiciliary care (applicant's own words):

What treatment issues (relapse cues / triggers) do you need to work on?

Have you been in a Domiciliary before? ☐ Yes ☐ No. If so, when and where?

With whom are you living? _____

Current resident or living situation: (include address & phone number):

How long have you lived there? _____

Financial Resources:

- Employment \$ _____ DPA \$ _____ VA/SC \$ _____ VAN/SC \$ _____
SSI \$ _____ SSD \$ _____ Other \$ _____
- Do you have a claim or plan to file a claim for SSD or VA benefits? ☐ Yes ☐ No

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MEDICAL CONDITIONS:

Current Physical Health Problems:

How recent was your last PPD Test (MANTOUX) _____

- What was the result? ☐ Negative ☐ Positive.
- Any treatment? ☐ Yes ☐ No
- What type? _____

Significant Previous Physical Health Problems:

Current Medications:

Last Change in Medication (Date):

PSYCHIATRIC CONDITION:

Have you ever been diagnosed with a psychiatric illness? ☐ Yes ☐ No

- What diagnoses? _____

Current Psychiatric Problems: _____

- Current Medications: _____

- Last Change in Medications (Date): _____

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Previous Psychiatric Problems (Outpatient Treatments?):

Have you ever been hospitalized for these problems? ☐ Yes ☐ No

➤ If so:

Psychiatric Hospitalization History:

<u>Date</u>	<u>Hospital</u>	<u>Diagnosis / Condition</u>

Have you ever been to this Medical Center? ☐ Yes ☐ No

➤ When? _____ For What? _____

Homicidal / Suicidal Thoughts & Acts:

Have you ever felt so bad that you **thought** about killing yourself? ☐ Yes ☐ No

➤ When was the last time this happened? _____

➤ How were you thinking of doing it? _____

Have you ever **tried** to kill yourself? ☐ Yes ☐ No

➤ When did this happen (especially the last time)? _____

➤ How did you try to kill yourself? _____

Have you ever tried to kill someone or seriously thought about it? ☐ Yes ☐ No

➤ When was the last time? _____

➤ How far did you go? _____

Aggressive Behavior:

When was the last time you were in a physical fight? _____

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SUSTANCE ABUSE CONDITION:

Substance Abuse History:

<u>Drug of Choice</u>	<u>Years of Use</u>	<u>Amount Using</u>	<u>Frequency</u>

When did you last use any drugs or alcohol? _____

How did you support your addiction (with money)?

- | | |
|---|--|
| <input type="checkbox"/> Selling Drugs | <input type="checkbox"/> Stealing /shop lifting |
| <input type="checkbox"/> Disability / welfare | <input type="checkbox"/> Work |
| <input type="checkbox"/> Trading sex | <input type="checkbox"/> Other ðhustleö ó What type? _____ |

What is the longest period of sobriety? _____ Ending when?

Are you currently enrolled in Substance Abuse Outpatient Program? ☐ Yes ☐ No

➤ If applicable, indicate where: _____

Formal Inpatient Drug & Alcohol Rehabilitation Program History:

<u>Name of Rehab:</u>	<u>Year</u>	<u>Length of following Sobriety</u>

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VOCATIONAL CONDITION:

What is the farthest you went in school? _____

Other Training? _____

Work History:

- What was your longest job? _____
- How long did you work there? _____
- When did you leave? _____
- What was your most recent job? _____
- How long did you work there? _____
- When did you leave? _____
- What were the dates of your longest period of continuous employment?
 - Start date: _____
 - Ending date: _____

LEGAL CONDITION:

Current Legal Problems:

Any Open Warrants for your Arrest in any State? ☐ Yes ☐ No.

Are you on probation or parole? ☐ Yes ☐ No.

- If so, for what offense? _____
- Length of monitoring? _____
- Do you have any Court Dates? ☐ Yes ☐ No When? _____
 - For what offense? _____

Past Legal Problems:

- What is your longest period of incarceration? _____
 - For what offense? _____

Incarceration History:

<u>Date In</u>	<u>Date Out</u>	<u>Offense</u>

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PLANS & GOALS

Future Vocational / Employment Plans:

Do you have any physical conditions that would prohibit or limit your ability to work?

☐ Yes ☐ No

If so, what condition? _____

What is the extent of your limitations? _____

Do you have any mental disabilities that would prohibit or limit your ability to work?

☐ Yes ☐ No

If so, what condition? _____

What is the extent of your limitations? _____

Housing:

What neighborhood do you plan to live in after the program? _____

With whom do you plan to live with after the program?

☐ Relative ☐ With a Friend ☐ By Myself ☐ With Romantic Relationship

☐ In Long-term placement (other institution after a couple of months.)

Do you have a valid driver's license? ☐ Yes ☐ No

Do you own a car? ☐ Yes ☐ No

If so, do you plan to bring it to the dom? ☐ Yes ☐ No

Will you need to leave the Medical Center for any reason in the next 30 days?

☐ Yes ☐ No

If so why? _____

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IF ACCEPTED FOR THE DOMICILIARY PROGRAMS, YOU WILL BE EXPECTED TO MAINTAIN SOBRIETY (ABSTAIN FROM USE OF NON-PRESCRIBED DRUGS AND ALCOHOL) WHILE AWAITING ADMISSION.

Coatesville VA – SATU Referrals Only:

If sheltered in the Coatesville area:

- 1. Will you commit to attending at least 3 days per week of CVAMC outpatient treatment as required for Domiciliary admission?**
☐ Yes ☐ No
- 2. Will you also commit to attending a weekly group with the Domiciliary Social Worker?**
☐ Yes ☐ No

If sheltered outside of the Coatesville area, will you commit to attending at least 1 day per week of CVMA outpatient treatment, and at least 2 AA or NA meeting per week as required for Domiciliary admission? ☐ Yes ☐ No

I PLEDGE TO ADHERE TO THE ABOVE COMMITMENTS AND EXPECTATIONS.

(Applicant's Signature)

(Date)